PRINTED: 09/30/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		157590	B. WING			09/	06/2013
NAME OF PROVIDER OR SUPPLIER GEM CITY HOME CARE				STREET ADDRESS, CITY, STATE, ZIP CC 2346 S LYNHURST AVE STE 301 INDIANAPOLIS, IN 46241	DDE	•	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
G 000	INITIAL COMMENTS		GO	000			
	This visit was a Hom recertification survey. extended survey.						
	Survey Dates: Septe Partial Extended Surv 2013	mber 3-6, 2013 vey Dates: September 5 - 6,					
	Facility Number: 011	342					
	Provider Number:	157590					
	Surveyor: David Eri Health Nurse Surveyo	c Moran, BSN, RN, Public or					
	Census Service Type Skilled: 208 Home Health Aide Or Personal Care Only: Total: 208	nly: 0					
	Sample: RR w/HV: 5 RR w/o HV: 8 Total: 13						
	Quality Review: Joyce September	e Elder, MSN, BSN, RN 17, 2013					
G 110	9/27/13. je	ified as the result of an IDR	G 1	110			
	Subpart I of part 489	th the requirements of of this chapter relating to					
_ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE			(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

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G 110	maintaining written p regarding advance d The HHA must inform information to the pa its policies on advan- description of applica may furnish advance patient at the time of	olicies and procedures	G 1 ²	10	
	Based on admission and interview, the agpatients were provided directives, including a State law, in 5 of 5 previewed during home.	not met as evidenced by: a packet review, observation, lency failed to ensure led the Indiana advance a description of applicable latient admission packets lie visits with the potential to lihis agency. (#1, #2, #3, #4,			
	evidence the Indiana effective May 2004 d 2. The home folder t 8/23/13, failed to cor Directives effective N	nission packet failed to Advanced Directives locument. For patient #1, start of care stain the Indiana Advanced May 2004 document within t during the home visit on			
	8/30/13, failed to cor	for patient #2, start of care stain the Indiana Advanced May 2004 document within			

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G 110	9/4/13 at 9 AM. 4. The home folder for 8/14/13, failed to combine Directives effective for the admission packer 9/4/13 at 10:30 AM. 5. The home folder for 8/30/13, failed to combine Directives effective for the admission packer 9/4/13 at 1 PM. 6. The home folder for 7/26/13, failed to combine Directives effective for the admission packer 9/4/13 at 3 PM. 7. On 9/3/13 at 2:15 Administrator, indicative were not solely for Information Directives D	or patient #3, start of care stain the Indiana Advanced May 2004 document within the during the home visit on for patient #4, start of care stain the Indiana Advanced May 2004 document within the during the home visit on for patient #5, start of care stain the Indiana Advanced May 2004 document within the Indiana Advanced May 2004 document wi	G 11	0			
G 159	packet. 484.18(a) PLAN OF The plan of care dev the agency staff cove including mental stat equipment required, prognosis, rehabilitat limitations, activities requirements, medic safety measures to p	eloped in consultation with ers all pertinent diagnoses, us, types of services and frequency of visits, ion potential, functional permitted, nutritional ations and treatments, any	G 15	9			

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(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
		G 1	59	
Based on clinical re the agency failed to included on the plan records reviewed wi patients at this agen	cord review and interview, ensure all medications were of care in 1 of 13 clinical th the potential to affect all			
Clinical record #7 evidenced a docume Supplemental" that i added to the medica	ent titled "Medication Profile - ndicated Amoxicillin was ation profile on 4/10/13. The			
Administrator, indicatorder needed to be the medication need	ated a MD signed Amoxicillin within the patient's record and led to be on the plan of car.	G 2	36	
current findings in ac professional standar patient receiving hor addition to the plan of appropriate identifying physician; drug, diet orders; signed and conotes; copies of sum	ccordance with accepted rds is maintained for every me health services. In of care, the record contains ng information; name of ary, treatment, and activity dated clinical and progress namery reports sent to the			
	ROVIDER OR SUPPLIER **HOME CARE SUMMARY S (EACH DEFICIENT REGULATORY OF REGULATORY O	THOME CARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all medications were included on the plan of care in 1 of 13 clinical records reviewed with the potential to affect all patients at this agency. (#7) Findings include: 1. Clinical record #7, start of care (SOC) 3/22/13, evidenced a document titled "Medication Profile - Supplemental" that indicated Amoxicillin was added to the medication profile on 4/10/13. The plan of care failed to evidence an order for	This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all medications were included on the plan of care in 1 of 13 clinical records reviewed with the potential to affect all patients at this agency. (#7) Findings include: 1. Clinical record #7, start of care (SOC) 3/22/13, evidenced a document titled "Medication Profile - Supplemental" that indicated Amoxicillin was added to the medication profile on 4/10/13. The plan of care failed to evidence an order for Amoxicillin. 3. On 9/6/13 at 1:56 PM, employee X, Administrator, indicated a MD signed Amoxicillin order needed to be within the patient's record and the medication needed to be on the plan of car. 484.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the	ROVIDER OR SUPPLIER 157590 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 3 any other appropriate items. This STANDARD is not met as evidenced by: Based on clinical record review and interview, the agency failed to ensure all medications were included on the plan of care in 1 of 13 clinical records reviewed with the potential to affect all patients at this agency. (#7) Findings include: 1. Clinical record #7, start of care (SOC) 3/22/13, evidenced a document titled "Medication Profile - Supplemental" that indicated Amoxicillin was added to the medication profile on 4/10/13. The plan of care failed to evidence an order for Amoxicillin. 3. On 9/6/13 at 1:56 PM, employee X, Administrator, indicated a MD signed Amoxicillin order needed to be within the patient's record and the medication needed to be on the plan of care. 48.4.48 CLINICAL RECORDS A clinical record containing pertinent past and current findings in accordance with accepted professional standards is amiantianed for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the

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G 236	This STANDARD is Based on record re agency failed to enscorrect in 1 of 13 repotential to affect al (#10). The findings include 1. Clinical record # included a documer with an order date of 650 mg every night Sodium 10 mg by m8/15/13. The docur ordered date as 8/1 2. During an interviemployee X, Admin date should have be 484.55(c) DRUG Riffects and drug reading in order to ide effects and drug readrug therapy, signiff drug interactions, dinoncompliance with This STANDARD is Based on clinical rethe agency failed to was updated and ac medication changes	eview and interview, the sure all entries were clear and cords reviewed with the I patients receiving services 10, Start of Care 7/26/13, and titled "Telephone Order" of 9/5/13 for Tylenol Arthritis by mouth and Pravastatin nouth every night effective ment failed to show the 5/13. ew on 9/5/13 at 5:31 PM, istrator, indicated the order een 8/15/13 and not on 9/5/13. EGIMEN REVIEW e assessment must include a ations the patient is currently entify any potential adverse actions, including ineffective ideant side effects, significant and undrug therapy. Is not met as evidenced by: ecord review and interview, ensure the medication profile courate when there were is in 2 of 13 clinical records otential to affect all patients at	G 23			

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G 337	Findings include: 1. Clinical record #7, included a document Supplemental" that in was added to the medication profile fails signature that these not reviewed. 2. Clinical record #8, included a document Supplemental" that in Hydrocodone-Acetam medication profile on profile failed to evider medication had been 3. On 9/6/13 at 1:59 Administrator, acknowledged.	start of care (SOC) 3/22/13, titled "Medication Profile - dicated that Hydralazine dication profile on 4/8/13 dded on 4/10/13. The ed to evidence a RN nedications had been start of care (SOC) 8/5/13, titled "Medication Profile - dicated that ninophen was added to the 8/14/13. The medication nice a RN signature that this reviewed. PM, employee X, wledged the RN needed to nedication profile each time	G	337			